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August 28, 2006

Josiah Dahlstrom,
Beacon Hospital Of Pocatello
1200 Hospital Way
Pocatello, ID 83201

Dear Mr. Dahlstrom:

On August 9, 2006, a complaint investigation survey was conducted at Beacon Hospital Of Pocatello. The survey was conducted by Penny Salow, Registered Nurse and Deb Dore, Registered Nurse. This report outlines the findings of our investigation.

Complaint # ID00001556

Allegation #1: The treatment team recommended the patient be sent to a skilled nursing facility (SNF). The family left to discuss where to send her. Before they called the social worker to tell her their decision, the patient was transferred over to the attached SNF. Two days later, the patient was transferred back to hospital without notifying the family.

Findings: An unannounced visit was made to investigate the complaint. During the investigation, staff were interviewed, patients were observed, and reviews were conducted of closed medical records, policies, and the hospital's grievance log and activities.

Closed records for six patients, who had been discharged to acute care hospitals, were reviewed. The records contained ongoing progress notes related to discharge planning activities, which were written by the social worker. The notes reflected frequent contact with patients' families and/or legal representatives and decisions related to placement.

The closed record for Patient #2 contained documentation by the social worker related to a treatment team meeting on 6/13/06. The patient's daughter, who had durable power of attorney (DPOA), was present for the meeting.

The patient's status was discussed and no barriers to discharge were identified. The notes stated "Family opts for placement at rehab - no placement at Syringa due to cost - as per family. Encouraged family to visit 3 SNFs in area - Family opts for Beacon Rehab - for transition & continuity of care - with Dr. Willey". The following day, the social worker gave copies of the discharge documents to the social services staff and Director of Nursing of Beacon Rehab and completed the discharge summary. According to the record, the patient was transferred to Beacon Rehab on 6/14/06 and returned to the hospital on 6/16/06. Physician progress notes, dated 6/16/06, stated the discharge was canceled because "the family had some very serious concerns about her being moved to another facility at this time".

Patient #2's record contained 23 social worker progress notes related to discharge planning between 5/19/06 and 6/27/06. Notes described 11 contacts with four assisted living facilities and one contact with a long term care facility. Contacts, or attempted contacts, with the patient's son and daughter/DPOA were noted twelve times related to placement decisions and discharge planning. In addition, progress notes indicated the son and/or DPOA attended five treatment team meetings, which included discussions of discharge plans.

The social worker was interviewed on 8/9/06 at 2:30 PM. She stated the patient's daughter was present at a treatment team meeting on 6/13/06. The patient's discharge was discussed and choices were provided. She stated it was her understanding that the daughter had decided the patient was to be transferred to Beacon Rehab.

Conclusion: Based on documentation and interview with the social worker, it was determined that the requirements for discharge planning were met. No deficiencies were cited.

Allegation #2: A patient, who was hospitalized from 5/15/06 - 6/28/06, lost more than 20 pounds in 5 weeks.

Findings: During the investigation, closed records for six patients, who had been discharged to acute care hospitals, were reviewed. Each record contained a nutritional assessment, documentation of intake per meal and at least weekly weight measurement. Only one of the six patients' records reflected weight loss.

Patient #2 was documented as weighing 154 pounds at the time of admission. The patient's record contained documentation that the patient was wandering, pacing, agitated and anxious on 30 of 42 days of her hospital stay. On 5/30/06, the patient was described as anxious, agitated, threatening, running everywhere, pacing non-stop and abusive. Notes also indicated the patient periodically refused to eat because she thought she was being poisoned. In addition, the patient was documented as being over-sedated and unable to eat for three days. A nursing care plan related to her nutritional status and behaviors had been developed. The patient was assisted to eat and her intake was recorded. The patient weighed 139 pounds prior to discharge, a loss of 15 pounds.

Conclusion: A system was in place to evaluate patients' nutritional needs and provide therapeutic diets. Patients' weights were monitored and supplements ordered, as indicated. Patients were assisted with meals as needed. Based on Patient #2's behaviors and long periods of heightened activity, her weight loss was probably not preventable. No dietary issues were identified and no deficiencies were cited.

Allegation #3: A patient's condition worsened & MD ordered a CT Scan. Staff told daughter they scheduled it when they hadn't. CT scan was not done until after she was transferred to the rehab side (SNF).

Findings: During the investigation, closed records for six patients, who had been discharged to acute care hospitals, were reviewed. Only one of the six patients' records contained an order for a CT scan.

Patient #2's record contained a physician's order, dated 6/13/06 at 5:40 PM, that stated "CT scan of head - change in consciousness x 1 week, more confusion - possible subdural". The CT scan was completed on 6/15/06. The CT scan report indicated the patient did not have a subdural.

The Director of Nursing was interviewed on 8/9/06 at 2 PM related to the delay in completing the CT scan. He stated the scan was not considered an emergency and was done as soon as it could be scheduled. The social worker, interviewed on 8/9/06 at 2:30 PM, stated she was told the scan was not an emergency and could be completed after discharge.

Conclusion: No evidence was found to indicate the CT scan was ordered to be performed on an emergent basis. The scan was scheduled and completed as soon as possible, based on provider availability. The CT scan report did not identify an emergent condition. The requirements for nursing services were met and no deficiencies were cited.

Allegation #4: A patient's family took time off of work and traveled to attend a treatment team meeting. When they arrived they were told it had been changed to the next day. No one called to tell them it had been changed.

Findings: During the investigation, staff were interviewed, and reviews were conducted of closed medical records, policies, and the hospital's grievance log and activities.

Closed records for six patients, who had been discharged to acute care hospitals, were reviewed. The records contained treatment team meeting minutes and interdisciplinary progress notes related to treatment team discussions and decisions.

Patient #2's record contained a treatment team review document which reflected the change of meeting date from 5/24/06 to 5/25/06. It also contained a social worker progress note, dated 5/24/06, which stated "son, daughter and DIL (daughter-in-law) in for tx mtg. SS (social services) neglected to inf. of mtg. change to 5/25/06 @ 12:45". The note indicated a conference call would be scheduled for the treatment team meeting the following day.

Subsequent notes reflected family notification and attendance at four treatment team meetings.

The social worker was interviewed on 8/9/06 at 2:30 PM. She stated the patient's physician did not have a regular schedule for treatment team meetings. She stated the meeting was changed at the last minute and she did not notify the family. She stated she apologized to the family.

The facility's grievance process was reviewed. No documentation was found to indicate other patients' family members had voiced complaints related to a lack of notification or communication.

Conclusion: Based on staff interview and review of medical records and grievance process documentation, it was determined the lack of notification was an isolated incident. No pattern of deficient practice was identified and no deficiencies were cited.

Allegation #5: A patient's family members were told that the patient shouldn't have visitors for the first full week, then later told family they never said that.

Findings: During the investigation, staff were interviewed, and reviews were conducted of closed medical records, policies, and the hospital's grievance log and activities.

Closed records for six patients, who had been discharged to acute care hospitals, were reviewed. The records contained treatment team meeting minutes and interdisciplinary progress notes which reflected frequent contact with and visitation by family members and approved visitors.

Patient #2's record contained a social worker progress note, dated 5/24/06, which stated the patient's son was upset that the night nurse had told them there was no visitation until after the first treatment team meeting, but the patient's niece had been allowed to visit the patient. The note indicated the Director of Nursing would investigate the occurrence.

The Director of Nursing was interviewed on 8/9/06 at 2 PM. He stated the hospital did not restrict visitation, although the patient's legal representative had the right to approve which visitors were permitted to visit the patient. He stated unless family visits exacerbated the patient's behaviors, they were asked to visit frequently. When asked about Patient #2, he stated an investigation had been conducted and acknowledged a nurse gave erroneous information to Patient #2's family. The nurse was counseled. This information was confirmed by policy review and corroborated by the social worker during an interview on 8/9/06 at 2:30 PM.

Conclusion: No evidence was found to indicate the hospital denied family visitation or access to patients. Although one employee gave incorrect information to a patient's family, no other problems related to visitation were identified. Patients' Rights requirements were met and no deficiencies were cited.

Allegation #6: The facility was not sure of the patient's code status even though they had been provided with a copy of the patient's Living Will. The patient's record said do everything for her, but patient was a no code.

Findings: During the investigation, staff were interviewed, and reviews were conducted of closed medical records and hospital policies.

Closed records for six patients, who had been discharged to acute care hospitals, were reviewed. The records contained evidence that as part of the admission process, patients and/or their legal representatives were notified of their rights, including the right to formulate advance directives. The records contained "Code Status Summary" forms, copies of living wills, as indicated, and physicians' orders related to the patients' code status.

Patient #2's record contained admission orders, signed and dated by the physician on 5/15/06. Order number five, related to advance directives, indicated the patient was a "Full Code". The record also contained a "Code Status Summary" form, signed by the patient's daughter on 5/15/06, that selected "Option 1 - full code".

Social worker progress notes, dated 5/15/06, stated the patient was a full code. The progress note stated the patient's daughter was the DPOA and signed the patient's admission paperwork. A progress note, dated 6/12/06, stated "Contacted DPOA & req. DPOA - paperwork & living will". The "Code Status Summary" form was changed to "no code" and initialed by the social worker and daughter on 6/12/06. A copy of the patient's living will was present in the record. The identification tag on the binder containing the patient's medical record stated the patient was "DNR" (Do Not Resuscitate).

The social worker was interviewed on 8/9/06 at 2:30 PM. She stated the patient was a full code initially. She stated when the patient's daughter brought in a copy of the patient's living will, the patient's status was changed to DNR. A review of hospital policies determined the policy for advance directives was followed.

Conclusion: No Patients' Rights issues were identified and no deficiencies were cited.

Allegation #7: A patient's family/legal representatives were not consulted about medication changes. The family was told the patient refused her Parkinson's medication, but the physician had discontinued it. The family told the physician they did not want patient to be given Haldol, but the patient was given the drug several times against their expressed wishes.

Findings: During the investigation, closed records for six patients, who had been discharged to acute care hospitals, were reviewed. Each record contained documentation of medication changes, as needed, in an effort to manage their behaviors. Records indicated patients' status, behaviors and medication adjustments were discussed at treatment team meetings where family members/legal representatives were present.

Five of the six patients' records reflected frequent medication adjustment without over-sedation.

Patient #2, whose diagnoses included depression, anxiety, Parkinson's with dementia, psychosis, paranoia and confusion, had admission orders, dated 5/15/06, which included Stalevo 100 mg four times daily and Requip 1.25 mg four times daily for treatment of Parkinson's. Physician's orders on 5/16/06 reduced the Requip to 1 mg four times daily. Physician orders on 5/28/06 stated "Hold Stalevo and Requip". The care of the patient was transferred to another physician on 5/31/06. Following a consult with the patient's regular physician on 6/13/06, an order was received to restart Stalevo at 50 mg three times daily. Stalevo was increased to 100 mg three times daily on 6/24/06 and the patient was discharged at that dose. The Requip was never reordered.

According to interdisciplinary progress notes, the patient's medication compliance varied during her hospitalization. Some days she was able to take medications without difficulty. Documentation indicated that between 5/27/06 and 5/30/06, the patient refused her medications (spit them out). Between 6/2/06 and 6/8/06, the patient was documented as refusing medications, food and care. Between 6/10/06 and 6/14/06, the patient was unable to take medications due to sedation. The patient was documented as again refusing medications between 6/23/06 and 6/26/06.

During the patient's hospitalization from 5/15/06 to 6/27/06, 50 physician's orders were written for changes in medications including new medications, dose increases or decreases, discontinued medications, changes to time of day for administration, or medications to be held. Because patients are admitted for medication adjustments or trials of medications to manage behaviors, medication orders are changed frequently. As a result, medication changes are discussed with the patients' families/legal representatives. The record indicated the patient's status and medications were discussed with Patient #2's family members on 5/24, 5/25, 5/31, 6/6, 6/13 and 6/20/06.

The patient's record contained documentation that the patient was wandering, pacing, agitated and anxious on 30 of 42 days of her hospital stay. On 5/30/06, the patient was described as anxious, agitated, threatening, running everywhere, pacing non-stop and abusive. On 6/6/06, the patient was documented as agitated and physically assaultive. A physician's order was written on 6/6/06 for Haldol 2 mg + Ativan 1 mg by mouth or by injection once daily as needed for severe agitation x five days. On 6/7/06, the patient was wandering, confused, disrobing in public and verbally aggressive. On 6/8/06, the patient was wandering and resistive to cares. Documentation indicated the patient was given Haldol 2 mg and Ativan 1 mg on 6/8/06. On 6/9/06, the physician ordered Haldol 2 mg with Ativan 1 mg by mouth at 8:30 PM. The medication was given as ordered. The patient was documented on 6/10/06 - 6/14/06 as being over-sedated and the Haldol and Ativan orders were placed on hold. Between 6/17/06 and 6/27/06, the patient was again pacing, agitated, yelling at peers, anxious, wandering, refusing medications, and unable to sleep.

On 6/24/06, the physician ordered Haldol 2 mg with Ativan 1 mg by mouth daily at 9 PM. The medication was given as ordered on 6/24 and 6/25/06. The physician ordered the 6/26/06 dose of Haldol and Ativan to be held, even though the patient was described as confused, tearful, wandering and pacing. On the day of discharge, the patient was described as drowsy, but easily aroused.

Although physician progress notes reflected ongoing discussions with the patient's family, no documentation was found to indicate the patient's family/legal representative told the physicians that they did not want the patient to be given Haldol. Documentation reflected the medication was only given as a last resort, when the patient's behaviors were not able to be managed and posed a risk to the patient and her peers.

The Director of Nursing was interviewed on 8/9/06 at 2 PM. He stated he was not aware of any request that the patient not be given Haldol. He acknowledged the medication had not had the desired effect the first time the patient was a danger to herself and others.

Conclusion: Based on record review and staff interview, it was not possible to determine if Haldol was given against the wishes of the family. According to the record, the family attended treatment team meetings during which medications were discussed. No Patients' Rights issues were identified and no deficiencies were cited.

As none of the complaints were substantiated, no response is necessary. Thank you for the courtesies and assistance extended to us during our visit.

Sincerely,

PENNY SALOW
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw